PEHP Health & Benefits

QHDHP

Summit Exclusive

MEDICAL BENEFITS GRID: WHAT YOU PAY

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

Percentages indicate your share of PEHP's In-Network Rate.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $1,500 Double/family plans: $3,000 *For double/family plans, one person or a combination can meet the $3,000 deductible*	Single plans: $1,500 Double/family plans: $3,000 *For double/family plans, one person or a combination can meet the $3,000 deductible*
Plan year Out-of-Pocket Maximum	Single plans: $2,800 Double/family plans: $5,600 *For double/family plans, no one individual will pay more than $2,800 maximum*	Single plans: $2,800 Double/family plans: $5,600 *For double/family plans, no one individual will pay more than $2,800 maximum*
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Wellness Care includes, but not limited to: pap smear, mammogram, prostate screening, gynecological exam, routine physical exam, routine vision exam for children, routine hearing exam for children, immunizations and related laboratory blood tests, colonoscopies. Other preventive services as identified by the Patient Protection and Affordable Care Act (PPACA) will be covered. Including Women's Preventive Care Act*	No charge	40% after deductible
PROFESSIONAL SERVICES		
PEHP e-Care / Telemedicine	**Medical:** $10 co-pay per visit after deductible	Not applicable
PEHP Value Clinics	**Medical:** 20% after deductible	Not applicable
Primary Care Visits | *Includes office surgeries and inpatient visits*	20% after deductible	40% after deductible
Specialist Visits | *Includes office surgeries and inpatient visits*	20% after deductible	40% after deductible
Surgery and Anesthesia	20% after deductible	40% after deductible
Emergency Room Specialist Visits	No charge after deductible	No charge after deductible
Diagnostic Tests, Labs, X-rays *Preauthorization required on PET scan only*	20% after deductible	40% after deductible
Mental Health and Substance Abuse	20% after deductible	40% after deductible
PRESCRIPTION DRUGS | ***All pharmacy benefits for the QHDHP are subject to the deductible.***		
30-day Pharmacy | *Retail only* Customer Service: 800-334-8134 www.optumrx.com Rx Bin: 610011 RxPCN: IRX RxGRP: RXBENEFIT	**Generic:** 20% **Brand Formulary:** 20% **Brand/Non-Formulary:** 20% **Specialty:** 20%	Not covered
90-day Pharmacy | *Maintenance only* Customer Service: 800-334-8134	**Generic:** 20% **Brand Formulary:** 20% **Brand/Non-Formulary:** 20%	Not covered

In- and Out-of-Network deductibles and Out-of-Pocket Maximums are combined and accumulate together.

*Out-of-Network Providers may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or Out-of-Pocket Maximum.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	20% after deductible	40% after deductible
Urgent Care Facility	20% after deductible	40% after deductible
Emergency Room *If admitted, inpatient facility benefit will be applied*	20% after deductible	20% after deductible
Ambulance (ground or air)	20% after deductible	
Diagnostic Tests, Labs, X-rays *Preauthorization required on PET scan only*	20% after deductible	40% after deductible
Chemotherapy, Radiation, and Dialysis *Requires Preauthorization*	20% after deductible	40% after deductible
Physical Therapy *Up to 40 visits per plan year*	20% after deductible	40% after deductible
Occupational & Speech Therapy *Up to 20 visits per plan year, per therapy class*	20% after deductible	40% after deductible
Mental Health & Substance Abuse	20% after deductible	40% after deductible
INPATIENT FACILITY SERVICES		
Medical & Surgical *Preathorization may apply. See Master Policy for details*	20% after deductible	40% after deductible
Skilled Nursing Facility *Requires Preauthorization*	20% after deductible	40% after deductible
Hospice	20% after deductible	40% after deductible
Rehabilitation *Requires Preauthorization*	20% after deductible	40% after deductible
Mental Health & Substance Abuse *All services require Preauthorization*	20% after deductible	40% after deductible
Residential Treatment Facilities *Requires Preauthorization*	20% after deductible	40% after deductible

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption *See Master Policy for benefit limits*	20% after deductible, up to $4,000 per adoption	
Allergy Serum	20% after deductible	40% after deductible
Chiropractic care | *Up to 40 visits per plan year*	20% after deductible	Not covered
Durable Medical Equipment *Visit www.pehp.org for complete list. See Master Policy for benefit limits*	20% after deductible Summit Network: Alpine Home Medical	40% after deductible
Medical Supplies *See Master Policy for benefit limits*	20% after deductible	40% after deductible
Home Health *Up to 60 visits per plan year*	20% after deductible	40% after deductible
Injections *Includes allergy injections. See above for allergy serum*	20% after deductible	40% after deductible
Infertility Services | *Includes testing. Does not include treatment. See Master Policy for details*	20% after deductible	40% after deductible
Temporomandibular Joint Dysfunction *Non-surgical*	20% after deductible	40% after deductible
Vision Exam for Adults	20% after deductible	40% after deductible

Failure to obtain prior authorization may result in a penalty of $200 or denial of benefits.

Any non-allowed or not covered amounts or services are the responsibility of the patient and are not included in the Out-of-Pocket Maximum.

RAPS: services provided by facility based radiologists, anesthesiologists, pathologists, labs, or ER physicians covered under the appropriate facility benefit.

Newborns are automatically covered for 30 days and to continue coverage they must be added to the plan within 30 days of birth.

Dependents Covered to Age 26 Regardless of student or marital status. Coverage terminates the end of the month in which the dependent turns 26.

Timely Filing - Claims must be filed within 12 months from the date the service incurred.

Life Threatening services incurred at a non network provider will be paid as in network.

Rural Area is defined as 30 miles. If covered services are not available in the network within 30 miles the provider will be paid in network.

Out of Country Care will be paid in network for medical emergencies only.